Referral Form

Dr. Vargas Lowy
Child Neurology

To send referrals, fax. to 603-600-7864 or email to childneuro@drvargaslowy.com

Provider Information

Provider NPI

Referring Provider Name

Provider Email

Primary Care Provider

Clinic Information

Clinic Name

Street address

Address cont.

City

State Postal Code

Phone number

Fax number

Contact name

Patient Information

Is family/patient aware of the referral?
If No, please make them aware as soon as possible.

Last name, First name

Date of Birth MM/DD/YYYY

Patient address

Address cont.

City

State Postal code

Primary contact

Relationship to patient

Home phone

Cell phone

Email

Patient Insurance Payer

Insurance Member ID

Continued on back.

*This information is required to complete a referral.

Patient Information (continued)

Reason for Referral:*

Diagnosis/Symptoms:*

Additional Medical History Information:

Additional Documents:
Please fax to 603-600-7864

- Patient face sheet.*
- Clinic notes, including diagnoses or problem lists.
- Relevant family history.
- Relevant test (lab or imaging) results.
- Current medication list and allergies.
- Current care management plans or recent referrals for therapies, medical equipment, etc.
- Diagnosis of mental health condition, substance abuse or behaviors affecting health.

*This information is required to complete a referral.